

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3222 S 125 E SHELBYVILLE, IN 46176
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W000000	<p>This visit was for the annual recertification and state licensure survey. This visit included the investigation of complaint #IN00160574.</p> <p>Complaint #IN00160574: Substantiated, federal and state deficiency related to the allegation was cited at W149.</p> <p>Dates of Survey: 2/2/15, 2/3/15, 2/4/15, 2/5/15 and 2/6/15</p> <p>Facility Number: 000760 Provider Number: 15G237 AIMS Number: 100243330</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/18/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure day service staff working with client A were trained to implement client A's BDP (Behavior Development Plan).</p> <p>Findings include:</p> <p>Day Service Staff (DSS) #1 was interviewed on 2/4/15 at 10:45 AM. DSS #1 indicated she was one of client A's direct supervisors at the day services. DSS #1 indicated client A had recently physically assaulted/slapped her. When asked if DSS #1 implemented the physical management/containment portion of client A's BDP addressing physical aggression, DSS #1 stated, "No, I was able to block her but I haven't been trained on holds (containments)."</p> <p>Day Services Program Manager (DSPM) #1 was interviewed on 2/4/15 at 11:10 AM. DSPM #1 had an IIR (Internal Incident Report) dated 1/13/15. DSPM #1 indicated DSS #1 had not been trained to implement the physical management/containment portion of client A's BDP.</p> <p>The day services IIR's were reviewed on 2/4/15 at 11:15 AM. The review indicated the following:</p>	W000120	<p>The day program staff who work with client A will be trained completely on the implementation of her behavior development program. This will include training on how to use the proper physical interventions to block aggression and to apply containments when needed. The staff who was not adequately trained will attend a formal physical interventions training provided by DSA Inc. so as to ensure she is adequately trained. The DSA administrator will also meet with the day program administrator to implement a procedure that ensures that day program staff who work with Client A and other residents of the facility have the training needed to implement their program plans. Minimally this plan will include the need for the day program to communicate when there is a staffing change and staff who need training. DSA management also routinely visit the day program, during these visits the management staff will talk with staff they observe working with Client A and other clients from the facility to ensure they are trained.</p> <p>Responsible Party: Area Director</p>	03/08/2015			

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	<p>-IIR dated 1/13/15 indicated, "[Client A] stole CD's off an (sic) participant (peer) than (sic) got upset (sic) started kicking supervisor desk and knocking over boxes than (sic) punch and cursed at supervisor." The IIR dated 1/13/15 indicated, "How did you respond to the incident? Got plant manager."</p> <p>Client A's record was reviewed on 2/3/15 at 2:35 PM. Client A's BDP dated 10/2014 indicated client A's targeted behavior included, but was not limited to, physical assault defined as "Attempted or actual purposeful attacks directed at other people, which may include striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects." Client A's 10/2014 BDP indicated, "Responding to targeted problem behaviors: Physical Assault; (1.) Direct [client A] to stop the behavior; (2.) If [client A] continues implement area restriction; (3a.) If [client A] continues to display the behavior, using (physical management) techniques; apply the minimum amount of physical guidance needed to stop the behavior; (3b.) If physical containment is necessary to stop the behavior, contain [client A] until she has been completely calm for three minutes."</p>			

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W000149	<p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 sampled clients (A and C) plus one additional client (G), the facility failed to implement its policy and procedures to prevent staff to client physical abuse regarding client A, to complete thorough investigations regarding an incident of client to client aggression regarding clients A and C and an incident of client to client aggression regarding clients A and G.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/2/15 at 1:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 11/22/14 indicated, "On 11/22/14 it was reported that [staff #1] had slapped [client A] and then clocked out and left the home. [Staff #1] was immediately suspended and the</p>	W000149	All staff are trained on the agency policy regarding prevention of abuse and neglect at the start of their employment and no less than annually thereafter. DSA management staff have routine presence in the facility to monitor interactions between staff and clients. There was no prior indicator that staff #1 would slap client A. Immediately following the incident she was suspended and had no further contact with client A. DSA will continue to train staff and closely monitor how staff interact with the clients and respond to their behavior problems. Agency professionals who are assigned to complete investigations will receive training on the expectation to ensure any clients who are involved or witness an incident that is investigated are interviewed as part of the investigation. The detail of any interviews with clients will be included in the investigation summary. An agency administrator will be completing reviews of all completed investigations for the	03/08/2015			

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	<p>police were called. A member of [agency] management arrived at the home immediately after being informed. The [agency] manager met with the police and a police report was filed."</p> <p>-Investigation Summary Form (ISF) dated 11/24/14 indicated, "[Staff #1] did physically abuse [client A] by slapping her across the face after [client A] had hit her. This is abuse per agency policy and state and federal regulations."</p> <p>2. BDDS report dated 7/27/14 indicated, "While getting ready for dinner [client A] began to have a behavior and became aggressive with [client C], whom (sic) happened to be sitting next to her. [Client A] slapped [client C] in the face with an open hand leaving a red mark on the right side of [client C's] face. Staff was able to intervene and separate the two before it escalated even more."</p> <p>-ISF dated 7/29/14 indicated, "[Client A] aggressed towards [client C] and struck her on 7/27/14. Please investigate this incident." The 7/29/14 ISF did not indicate documentation of clients A or C being interviewed. The 7/29/14 ISF indicated, "Administrative Review: I concur with findings but have (sic) [client C] did flip [client A] off as that is not in her nature. [Client C] is vulnerable."</p>		<p>facility and agency.</p> <p>This administrator will ensure that clients have been interviewed as part of the investigation process when reviewing reports. If a submitted investigation does not include needed client interview(s) the professional responsible for completing the investigation will be directed to obtain the needed interview(s) and include in the report and re-submit it.</p> <p>Responsible Party: Area Director</p>	

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	<p>3. BDDS report dated 10/18/14 indicated, "It was reported on 10/17/14, [client G] and [client A] got into a verbal argument. [Client G] pulled [client A's] hair and [client A] bit [client G's] arm, breaking the skin. Both were able to be redirected and were calm following then incident. Basic first aid was applied and [client G] was taken to the ER (Emergency Room) for the injury to be evaluated and get bloodwork completed."</p> <p>-ISF dated 10/28/14 indicated, "On 10/17/14, [client A] and [client G] aggressed towards on (sic) another. During the incident, [client A] bit [client G] and broke the skin." The 10/28/14 ISF did not indicate documentation of clients A or G being interviewed or included in the investigation.</p> <p>AD (Area Director) #1 was interviewed on 2/3/15 at 1:45 PM. AD #1 indicated the facility's abuse and neglect policy should be implemented. AD #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly investigated.</p> <p>The facility's policies and procedures were reviewed on 2/5/15 at 12:45 PM. The facility's Abuse and Neglect policy</p>			

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W000154	<p>dated 10/2013 indicated, "Immediately upon receiving notification of the incident from the RD (Residential Director), the AD will initiate an investigation of the allegation(s) to provide a factual basis for management actions."</p> <p>This federal tag relates to complaint #IN00160574.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 9 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to complete thorough investigations regarding an incident of client aggression regarding clients A and C and an incident of client to client aggression regarding clients A and G.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed</p>	W000154	<p>Agency professionals who are assigned to complete investigations will receive training on the expectation to ensure any clients who are involved or witness an incident that is investigated are interviewed as part of the investigation. The detail of any interviews with clients will be included in the investigation summary. An agency administrator will be completing reviews of all completed investigations for the facility and agency. This administrator will ensure that clients have been interviewed as part of the investigation process when reviewing</p>	03/08/2015

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	<p>on 2/2/15 at 1:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 7/27/14 indicated, "While getting ready for dinner [client A] began to have a behavior and became aggressive with [client C], whom (sic) happened to be sitting next to her. [Client A] slapped [client C] in the face with an open hand leaving a red mark on the right side of [client C's] face. Staff was able to intervene and separate the two before it escalated even more."</p> <p>-ISF dated 7/29/14 indicated, "[Client A] aggressed towards [client C] and struck her on 7/27/14. Please investigate this incident." The 7/29/14 ISF did not indicate documentation of clients A or C being interviewed. The 7/29/14 ISF indicated, "Administrative Review: I concur with findings but have (sic) [client C] did flip [client A] off as that is not in her nature. [Client C] is vulnerable."</p> <p>2. BDDS report dated 10/18/14 indicated, "It was reported on 10/17/14, [client G] and [client A] got into a verbal argument. [Client G] pulled [client A's] hair and [client A] bit [client G's] arm, breaking the skin. Both were able to be redirected and were calm following then incident. Basic first aid was applied and [client G] was taken to the ER (Emergency Room)</p>		<p>reports. If a submitted investigation does not include needed clientinterview(s) the professional responsible for completing the investigation willbe directed to obtain the needed interview (s) and include in the report andre-submit it.</p> <p>Responsible Party: Area Director</p>	

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W000209	<p>for the injury to be evaluated and get bloodwork completed."</p> <p>-ISF dated 10/28/14 indicated, "On 10/17/14, [client A] and [client G] aggressed towards on (sic) another. During the incident, [client A] bit [client G] and broke the skin." The 10/28/14 ISF did not indicate documentation of clients A or G being interviewed or included in the investigation.</p> <p>AD (Area Director) #1 was interviewed on 2/3/15 at 1:45 PM. AD #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be thoroughly investigated.</p> <p>9-3-2(a)</p> <p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 3 of 4 sampled clients (A, B and D), the facility failed to ensure clients A, B and D or their guardians participated in the development of their ISPs (Individual Support Plans).</p>	W000209	Agency QIDP's will receive training to ensure that allclients or the client's guardians do participate in the development and updateof the clients Individual Support Plan (ISP). Meetings are being held to update the ISP's for clients A, B and D. Theclients are participating in	03/08/2015

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9-3-4(a)	<p>Findings include:</p> <p>Client A's record was reviewed on 2/3/15 at 2:35 PM. Client A's ISP dated 1/26/15 indicated client A had a legal guardian. Client A's 1/26/15 ISP did not indicate documentation of client A's guardian's signature or participation in the development of client A's 1/26/15 ISP.</p> <p>Client B's record was reviewed on 2/4/15 at 10:45 AM. Client B's ISP dated 4/13/14 indicated client B was an emancipated adult. Client B's 4/13/14 ISP did not indicate documentation of client B's signature or participation in the development of her ISP.</p> <p>Client D's record was reviewed on 2/4/15 at 8:16 AM. Client D's ISP dated 12/14/14 indicated client D was an emancipated adult. Client D's 12/14/14 ISP did not indicate documentation of client D's signature or participation in the development of her ISP.</p> <p>AD (Area Director) #1 was interviewed on 2/3/15 at 11:45 AM. AD #1 indicated the client or the client's legal guardian should participate in the development of the ISP.</p>		<p>these meetings. Client A's guardian is also participating in her meeting. Their participation will be evidenced by their signatures on their ISP and on a meeting note. The QIDP will submit completed ISPs with evidence of client and/or guardian participation as appropriate to the Administrator within 5 business days of completion. The administrator will develop and maintain a tracking system to ensure ISP's are completed as required and including the participation of the client and/or legal guardian in all facilities. QIDP's will be prompted by this administrator to ensure completion and submit any information that has not been provided as required.</p> <p>Responsible Party: Area Director</p>	

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (client B), the facility failed to ensure client B's ISP (Individual Support Plan)/BDP (Behavior Development Plan) described how staff should supervise client B during personal hygiene tasks and to address false allegations.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigation Summary Forms (ISFs) were reviewed on 2/2/15 at 1:00 PM. The review indicated the following:</p> <p>-BDDS report dated 5/12/14 indicated, "On 5/11/14, [client B] stated to [staff #5] that [staff #5] had hit her. [Staff #5] immediately informed the RD (Residential Director) on call of the allegation. [Staff #5] was placed on suspension and an investigation was immediately initiated. When asked during the course of the investigation if</p>	W000227	<p>The IST for client B reviewed her history of making false allegations including the most recent incident on 1/5/15. The IST reviewed this on 2/26/15. The team determined that as this client does not display any other problem behaviors that this issue could be addressed with a formal bathing, dressing and hygiene protocol. This protocol includes the presence of two staff when she is being provided assistance in these areas and was reviewed and approved by the team. All staff working in the facility will be trained on this protocol. On-going the administrator will ensure that programming needs identified from reportable incidents are met with the use of tracking system to note programming needs and dated completion information. This system will be reviewed no less than twice a month to ensure identified programming needs are being addressed properly. Responsible Party: Residential Director</p>	03/08/2015

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	<p>staff were nice to her, [client B] responded that they were. When asked if anyone had hit her, [client B] stated that no one had. [Client B] also indicated that [staff #5] specifically had not struck her at anytime. [Agency] was unable to substantiate the allegation as [client B] denies that anyone was inappropriate with her or had struck her."</p> <p>-BDDS report dated 5/28/14 indicated, "On 5/25/14, [client B] stated to staff member, [staff #4] that [staff #4] had hit her in the genital region. [Staff #4] informed the RD on call of the allegation. [Staff #4] was placed on suspension and an investigation was initiated. In an interview with [client B], she stated that [staff #4] had not hit her in her genital area or anywhere else. [Client B] stated that [staff #4] was nice to her. [Client B] also stated that no staff member had hit her or had been mean to her. [Staff #4] reported that she had assisted [client B] with personal care in her genital region after she had used the restroom as well as in applying some prescribed powders and cream. The investigation determined that the allegations were unsubstantiated." The 5/28/14 BDDS report indicated, "[Agency] will continue to monitor the health and safety of [client B] and continue to investigate all allegations of abuse and neglect. As this is the second</p>						

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	<p>incident where [client B] has made an allegation that was unsubstantiated the behavior consultant will be asked to review this incident to consider adding false allegations to [client B's] BDP."</p> <p>-BDDS follow up report dated 6/11/14 indicated, "A BDP will be developed to address the issue of making false allegations and for improving social skills. Anytime [client B] needs assistance with personal hygiene tasks two staff are present so as to provide witness to any reports that may be made."</p> <p>-BDDS report dated 1/6/15 indicated, "On 1/5/15, [client B] made an allegation to staff member, [staff #2], that [staff #3], another staff member, had touched her between her legs, while at the group home that evening. The alleged staff member was suspended in order to keep [client B] safe and an investigation in order to investigate the allegation (sic)." The 1/6/15 BDDS report indicated, "During the investigation, [client B] stated to two separate staff members that she lied and said 'I like [staff #3]'. At no time during the evening prior to the allegation was [staff #3] was alone with[client B]. [Agency] was unable to substantiate the allegation. The staff member was able to return to work. [Client B] does have an HRC (Human</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3222 S 125 E SHELBYVILLE, IN 46176			
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	<p>Rights Committee) approved BDP that addresses making false allegations."</p> <p>-ISF dated 1/7/15 indicated, "Recommendations; (3.) Staff are not to be one on one (supervision) with [client B]."</p> <p>Client B's record was reviewed on 2/4/15 at 8:45 AM. Client B's ISTMR(Individual Support Team Meeting Report) dated 1/22/15 indicated the review of client B's 1/6/15 allegation of sexual misconduct. Client B's ISTMR dated 1/22/15 indicated, "Continue to follow BDP as written. Staff have signed assertions stating that they understand that they are not to interact with [client B] one on one (supervision) on 1/17/15." Client B's ISTMR dated 6/26/14 indicated, "An IR (Incident Report) was filed for an incident on 5/25/14 when [client B] made a false allegation against a staff stating to the staff that she had hit her in the private area. She quickly retracted this report and stated the staff is nice to her. This is the second report of this nature. She has also frequently displayed crying which has appeared to be attention seeking. She also demonstrates some inappropriate social behavior. The staff currently have a staff witness when they assist her with any personal hygiene tasks. A BDP needs to be written and implemented to address</p>						

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	<p>anxiety.... The plan shall also, address false allegations and inappropriate social responses. The plan shall include a procedure for teaching appropriate social behavior." Client B's ISTRM dated 5/20/14 indicated, "On 5/11/14 [client B] made a false allegation on a staff member. The findings were investigated and [client B] admitted to making false allegations. She has hasn't (sic) had any behavior issues. She has been crying and upset more especially when a fellow housemates behavior is escalating." Client B's Bathing, Dressing and Hygiene Protocol (BDHP) dated 4/2/14 did not indicate documentation of how staff should supervise client B during personal hygiene tasks. Client B's record did not indicate documentation of a BDP.</p> <p>AD (Area Director) #1 was interviewed on 2/4/15 at 9:27 AM. AD #1 indicated client B had made false allegations against staff. AD #1 indicated client B should be supervised by two staff during personal hygiene tasks. AD #1 indicated client B should have a BDP to address false allegations.</p> <p>9-3-4(a)</p>			

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W000260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure client C's ISP (Individual Support Plan) was reviewed/revised annually.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 2/4/15 at 9:32 AM. Client C's ISP dated 4/10/13 did not indicate documentation of annual review/revision.</p> <p>AD (Area Director) #1 was interviewed on 2/4/15 at 10:30 AM. AD #1 indicated client C's ISP dated 4/10/13 had not been reviewed/revised since 4/10/13. AD #1 indicated client C's ISP should be reviewed annually.</p> <p>9-3-4(a)</p>	W000260	<p>The QIDP will ensure that all Individual Support Plans(ISP's) including client C's are revised/reviewed no less than annually. ClientC has moved to another group home since the survey. Agency QIDP's including theQIDP for this facility will be trained on this expectation. The QIDPs will submit completed ISPs to theAdministrator within 5 business days of completion. The administrator willdevelop and maintain a tracking system to ensure ISP's are completed asrequired and are current within the past year. QIDP's will be prompted by thisadministrator to ensure completion and submit any information that has not beenprovided as required. The QIDPs will be given a prompt of ISP's that are duefor revision/review no less than 30 days before they are due.</p> <p>Responsible Party: Area Director</p>	03/08/2015
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p>			

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	<p>Based on record review and interview for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H), the facility failed to conduct evacuation drills quarterly for each shift of personnel.</p> <p>Finding include:</p> <p>The facility's evacuation drill record was reviewed on 2/4/15 at 8:30 AM. The review indicated the facility failed to conduct evacuation drills for clients A, B, C, D, E, F, G and H for the overnight shift for the first quarter, January 2014, February 2014 and March 2014, the day shift for the second quarter of 2014, April 2014, May 2014 and June 2014, the day, evening and overnight shifts for the third quarter of 2014, July 2014, August 2014 and September 2014, the day and overnight shifts for the fourth quarter of 2014, October 2014, November 2014 and December 2014.</p> <p>AD (Area Director) #1 was interviewed on 2/3/15 at 1:00 PM. AD #1 indicated there was not additional documentation available for review regarding evacuation drills. AD #1 indicated the group home should conduct evacuation drills one time per quarter per shift of personnel.</p> <p>9-3-7(a)</p>	W000440	<p>The Residential Director for the home will be responsible for ensuring required fire evacuation drills are completed. Their completion will be scheduled on the staffing schedule. They will be scheduled so that a drill is completed for each shift of personnel no less than quarterly. Drills will be scheduled to be completed by the 10th of each month. The Residential Director will ensure completion within 3 business days. The Residential Director will provide the Administrator documentation within 5 business days to verify completion of the drill and the timing of the drill. Should the Administrator not receive verification of the completed drill by the 20th of each month, the Residential Director will be directed to conduct the required drill and submit record of the completed drill by the 25th. The Administrator will use a tracking system to ensure compliance. The Residential Director will also ensure a copy of each drill report is maintained in the home and available for review. This will be checked routinely by administrators completing visits in the facility. All agency Residential Directors will be trained on their responsibility to ensure completion of required fire evacuation drills.</p> <p>Responsible Party: Residential Director</p>	03/08/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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